



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RENAISSANCE HOSPITAL OF DALLAS
PO BOX 11527
HOUSTON TX 77293

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

INSURANCE CO OF THE STATE OF PA

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-08-1434-01

MFDR Received Date

OCTOBER 31, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our company has purchased national hospital payment data from 'Cleverly and Associates'; a nationally recognized company. The PAF we have established is 250% of our hospital specific Medicare Outpatient Prospective Payment System reimbursement rate; this rate is consistent with most commercial and private payers with in this region. This is slightly higher than the current TDI-DWC PAF established in rule 134.402 for Ambulatory Surgical Centers of 213.33%... The carrier has failed to prove our PAF is not fair and reasonable, thus Renaissance Hospital has met it's 'burden of proof' in this case."

Amount in Dispute: \$24,398.03

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Reimbursement already made based on carrier fair and reasonable rate & PPO adjustment mad per TX state standard under rule #134.202(d)(3). No further reimbursement due"

Response Submitted by: Specialty Risk Services, 300 S. State St., Syracuse, NY 13202

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
December 18, 2006	Outpatient Surgery	\$24,398.03	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on October 31, 2007.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W10 – No maximum allowable defined by Fee Guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology. Reduced to fair and reasonable.
 - 89 – Professional fees removed from charges. Services billed for radiology, lab, and/or pathology by a hosp. should be normally be billed at the TC rate.
 - 45 – Charges exceed your contracted/legislated fee arrangement. The charges have been priced in accordance to your fee for service contract with First Health.

Findings

1. The insurance carrier reduced or denied disputed services with reason code 45 – “Charges exceed your contracted/legislated fee arrangement. The charges have been priced in accordance to your fee for service contract with First Health.” On May 24, 2012 the Division requested a copy of the contract between Insurance Co of the State of PA and the informal/voluntary network, a copy of the contract between the information/voluntary network and Renaissance Hospital of Dallas and documentation to support that Renaissance Hospital of Dallas was notified pursuant to former 28 Texas Administrative Code §133.4. The insurance carrier agent submitted a response to the Divisions request stating, “The carrier asserts that it has paid according to the applicable fee guidelines and/or reduced to fair and reasonable. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines.” The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to services with reimbursement subject to the provisions of Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers’ compensation health care network shall be made in accordance with subsection §134.1(d) which states that “Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available.”
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(c)(2)(B), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include “a copy of each explanation of benefits (EOB)... relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB.” Review of the documentation submitted by the requestor finds that the request does not include a copy of the EOB detailing the insurance carrier’s response to the request for reconsideration. Nor has the requestor provided evidence of carrier receipt of the request for an EOB. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(B).
5. 28 Texas Administrative Code §133.307(c)(2)(F)(i), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include “a description of the health care for which payment is in dispute.” Review of the submitted documentation finds that the requestor has not provided a description of the health care for which payment is in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(i).
6. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable.” Review of the submitted documentation finds that:
 - The requestor’s position statement / rationale for increased reimbursement from the *Table of Disputed Services* asserts that “The PAF we have established is 250% of our hospital specific Medicare Outpatient Prospective Payment System reimbursement rate; this rate is consistent with most commercial and private payers with in this region. This is slightly higher than the current TDI-DWC PAF established in rule 134.402 for Ambulatory Surgical Centers of 213.33%...”
 - The requestor did not submit documentation to support that the PAF they have established is 250% of our

hospital specific Medicare Outpatient Prospective Payment System reimbursement rate; this rate is consistent with most commercial and private payers with in this region.

- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____	_____	September 27, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.